Statewide Healthcare Coalition Steering Committee Meeting – 01/26/2015

Topic	Discussion	Outcome/Action Items
Call to Order, Welcome and Introductions	The members of the group introduced themselves and were welcomed to the meeting. • This is Charlie's last meeting as Chair of this committee	Sign in sheet is attached
Review & Approval of October Meeting Minutes	• HANDOUT: Meeting minutes • October meeting minutes approved o No discussion	***Outcomes -*** Minutes were approved. ***Action items:*** None
Long Term Care Subcommittee Update	• Subcommittee developed in July • Not much development since last HCC Steering Committee meeting in the fall o Cannot make any connections, not even those in her region o The person at the state is more interested with disabilities and not with aging • Map of the long term care contacts o Virginia only found an old map o KDADs redone their districts o Shona Gleason has the new maps, she will contact the KDADs lead for nursing homes • Must get them involved/interested with the HCCs o Karen will travel to anywhere to encourage engagement within the HCC ▪ SW hasn't had people attending because they have no money an no staff, regardless of interest ▪ The HCC must connect with them, take the money and the education resources o Wichita contact ▪ Interested, but cannot leave Wichita, and cannot	***Outcomes -*** 1. Karen and Virginia will continue to reach out to the community members 2. Committee will hold off on including hospice as a member of this committee ***Action items:***

	travel o Long term care was recognized as a need for the HCC during the Ebola Response however, the spark is fading with the Ebola response o Sue has tried to engage Saline county, but they will not return her calls o The long term care will have to become more involved when CMS is implemented, however, it is better to be proative than reactive o A lot of nursing homes are attached to hospitals, but those that are stand-alone facilities, and assisted living are not interested o HCCs must stay diligent, the preparedness efforts in this demographic is not sufficient ▪ Not even good with fire and tornado drills • KDHE representation in Long Term Care o Not KDHE this is KDADs ▪ Contact is Audra ▪ Karen has reached out with no response • Introducing Hospice Care o Liz Ticer has a contact – Chris Duncan from Catholic Charities short term that is interested in joining, he is from hospice o Hospice has volunteered to be a member, should we invite them to the next meeting, is there a value to having hospice? ▪ Hospice brings a value at the regional level, maybe not at this level • Tom: hospice is a home health working with specific populations, home health should be represented at the local/regional level not at a state wide level ▪ Big difference, hospice is a private home,	

	nursing homes is a big facility • HCC's interest is in the facility care, not private home care at this time o Consensus is to hold off on hospice at this time • Contact lists o KDADs- none, have reached out with no response o Leading Age has a list of all members on their website o KS Healthcare probably has one	
Leading Age Representation on Steering Committee	• Leading Age o Contacted Ron Marshall o Represent 160 plus free standing long term care facilities and hospital members across Kansas o New educator believes long term care should practice exercising with the HCC ▪ Supervisor has her committed to attend the HCC meetings o Leading Age has conferences twice a year, and have invited us to have a vendor table, however the vendor table is very expensive, if HCC develops a relationship, maybe then HCC will not have to pay vendor rate o Do we want Leading Age to be a member of this committee ▪ May help HCC get more long term care facilities ▪ Is this committee becoming too big (see other business) ▪ Tom: maybe they need to present on their association then we can decide if they want to add Leading Age to the committee ▪ Ron: maybe allow Leading Age representative to attend a few meetings to see if they are interested in joining our meeting o At the very least, this will be an opportunity to show Leading age HCC is an emergency and disaster resource,	***Outcomes –*** 1. Votes: to allow Kansas Healthcare Association and Leading Age to present with the intention of allowing the committee to offer membership; to allow the representative from Leading Age to attend a meeting to determine if Leading Age would want to be a member ***Action Items:*** 1. Ron to contact Leading Age to present on their organization and to join the next meeting 2. Lisa to contact KS Healthcare Association to present on their organization and to join the next meeting 3. Steve, and others, to contact members of Leading Age/KS healthcare association on their opinions of their respective associations

	and HCC can find out how to get information out there from us, even if they don't join ▪ Do they have a monthly newsletter we can use to reach out to long term care facilities ▪ Can we start putting information out through their newsletter, to disseminate knowledge about HCC • Ron has given the flyer from Emily o Looked at the leadingagekansas.org website, viewed the map, note: they represent across the entire state ▪ The organization represent more facilities than anyone at this table • Kansas Healthcare Association o Another representor of long term care Cindy Luxum is the Director ▪ Lisa Williams has worked with them in the past and will contact them about HCC participation o Linda Farrrer is very active in the Kansas Healthcare Association, and may be a good contact o A quick internet search did not provide how many facilities this association represents ▪ Note: there are over 500 long term care facilities in the state, about 165 are represented by Leading Age, and the others are probably covered by another association. However, it was pointed out that a facility does not have to belong to an association • Julie: it is a very important time to contact the long term care facilities because the statewide tornado drill is coming up. The SN emergency manager has already sent them the statewide tornado drill information • Vote: All those in favor of having Leading Age come to the next meeting to present to optionally become a member of this committee?	

	○ Yay. ○ Note: it is not an automatic membership if you present, you still have to fill out an application • Vote: all those in favor of having KS Health Care Association present to potietially become a member of this committee? ○ Yay • Vote: all those in favor of having Leading Age Rep join a meeting to allow her to decide if she wants to be a member? ○ Yaya	
Coalition Exercise Planning Committee	• Tami is still out • The committee has not made any developments • Anticipating a Statewide Functional Exercise in 2017	***Outcomes –*** ***Action items*** –
KDHE Ebola Preparedness Efforts	• Was the Regional Ebola Forums effective and valuable? ○ "When the big guys come to the little guys it is very impressive, we had over 100 people at that presentation, and they spent several hours to talk to us little guys" ○ KC: had something similar, too old no new information, not even a month later ○ SC: led credibility to the topic, allowed the HCC to recruit people from the facilities that usually do not attend because the secretary was involved ○ SW: Dr. Bob was not available, and Dr. Mosier was sick, however it was really well received, but with the concerned acuity of the worry of Ebola down, 99 people signed up but there was only 77 attendees, which is very good for December 16 and that buys time. It brought some kind of calm to the community, and they had all the answers to the questions, and if not they were very gracious. The word travels very fast the secretary was involved, and it came across as genuine concern especially when the secretary is willing to	***Outcomes—*** ***Action items*** – 1. Charlie and Virginia will generate a response letter to send to Response2014@kdheks.gov 2. Laura will send the minutes to Charlie and Virginia so they have material for the letter

	answer all the questions. o NW: very well attended and received, well over 100 maybe even 200 people attended. It was on November 22 and the capstone of the fast paced Ebola series. Ebola wasn't at first considered a threat to NW KS, until it was realized Sheridan County identified people who had been in Africa, and also discovered a dozen students that wanted to go home to those countries. The Secretary was able to answer the questions, and as a layperson, he was really impressed with the secretary o SC: it was great because it wasn't just an information dump, the secretary and team took time to answer all the questions o SW: it was also very important for information gathering, it allowed people to consider more ideas, and spurs people even harder to work together and collaborate o SE: great coalition builder! The secretary brought in the largest attendance of the HCC, and it still has a higher attendance than before the Secretary presented. These forums helped to enforce how HCCs can bring benefits to the community o Very beneficial: we recommend if KDHE was a good central message, even if it isn't the most up to date and accurate, it is very important in a situation to get one standard message out o This allowed for counties to refocus their efforts on other preparedness activities, like the SOGs and isolation and quarantine ▪ Ebola brought to light communities may still have to quarantine and isolate members of the community for the best interest of public health, also helps with refocusing on other important ideas not usually focused on by	

	public health, like hazardous waste ▪ Showed many communities the importance of public health and the services it provides to the communities • Very understood Ebola forums were driven by Dr. Bob, how does the committee get this message is important to Dr. Mosier o Lisa: we will forward any information on, however it will be more effective to come from this committee o Lisa: we suggest sending a letter from the chair to the response2014 email to have the most impact • Concern on the Ebola forum o This need to not just to be for Ebola, it needs to be focused on all infectious diseases, because this is needed for all infectious diseases, not just Ebola ▪ They understand this might not have drawn the crowds because everyone is interested in EBOLA not just infectious disease ▪ The focus on Ebola was important because the PPE is vastly different than other infectious disease, and it was such a huge focus for this response • Suggestions for another statewide response o Maybe do a radio conference so all the state can hear the information at once and hear all the questions and all the answers at one time ▪ It seemed as if Dr. Bob's intent was to bring the community together and discuss the response in one place in one room, one of the best interactions was that a home care nurse from a small community spoke her mind, discussed her fears, and that is one of the voices that needed to be heard, and that may be lost in a statewide forum o Education would be nice to have statewide. Dr.	

Norman's discussion on the Grand Rounds came out to late, and it was hard to find. It would have been a great learning opportunity but it was missed by most people because the information wasn't sent out
    - Give a list of suggested community members to attend. Some partners did not attend because the lack of forethought to invite them to the meeting, for example, in the NE immediate care facilities were overlooked
- The QA from all the regions is available under the Ebola link on KDHE website
- There have been about 10-15 active monitoring cases in Kansas
- Charlie and Virginia will create a letter and send it to the KDHE email
- Ebola BUDGET (Tabetha has designated the Phases, that is NOT from the CDC/ASPR
    - Phase I
        - Application submitted Jan 16th
        - PHEP for $52,808
        - Duration December 22, 2014- June 30, 2015
        - Not distributed to the local level
            - Paying 20% Sheri Tubach's salary, KDHE Director of Infectious Disease Epidemiology and response who is instrumental with:
                - Response2014 email
                - Phone bank
                - Ebola Response Plan
                - Monitoring and reporting
    - Phase II
        - PHEP for Preparedness and Response activities
        - $1.6 million-funding on base plus population
        - April 1 2015-September 30, 2016
        - Application due February 20, 2015
        - 18 month project period

- We expect a significant amount will be pushed to the local level
  - Just getting together with what to do with the funding
  - Leadership is considering the same funding structure for the local level as currently used in base PHEP awards (base plus population)
  - CANNOT be used retroactively
  - May not go all local
- Phase III
  - HPP based funding, for Ebola Preparedness and Response, formula is base, population, risk (returning travelers)
  - Discussions are still underway at the federal level and these things are subject to change, but this is the information we currently have
  - $166 million total-we don't know what it looks like for Kansas yet
    - We should get the Funding Opportunity Announcement mid to late February
    - Talking 5 year budget period
      - Distributing funds in a lump sum or distributing the funds in smaller sums across the 5 years
  - Funding is designed to align with capabilities and can be used on:
    - Not Ebola specific in order to be used on other mostly infectious diseases
    - HCC support
    - PPE at the coalition level
      - Must be visible at the state level to all HCCs

	• ER isolation • Retrofitting rooms • Minor construction • Training • Point of care equipment • Lab testing • X-ray capabilities • Treating people under investigation • MOUs allowable • Can possibly be used retroactively from July 2014 • Trying to align PHEP, but we have no FOA • Information may change ▪ Do not know if it will be going to the regional or the local, HPP should mostly be pushed down to the local o EPI and Laboratory Capacity Grant ▪ Ensure their activities align with HPP and PHEP o Ebola treatment Centers ▪ Cannot commit to saying more money may go to them ▪ Treatment centers may get more money, it is part of the federal discussion already ▪ Please refer to "other business"	
HPP-PHEP Representatives Involved in Capability Work Session for Grant Application-Jamie	• HANDOUT: CABABIILTY PLAN GROUPS • Meetings are at the DOC (third floor, CSOB Topeka, Kansas), conference line is available • The time frame depends on the capability, usually 1 or 2 hours, but can take only 20 minutes • Is there any Public Health representative that would like to be involved? o Dan Pugh on 1 and 3	***Outcomes—*** Really need to focus on what we are going to develop for mental behavioral health ***Action items*** **–** 1. Those that signed up/agreed to attend the capabilities work sessions contact Jamie for further information

	○ Lougene Marsh on 4 ○ Ron 6 ○ Michael Burkhart on 5 ○ Julie on 12 • These work sessions will allow Jamie to draft the work plan deliverables, which will be finalized and distributed to the group • Tom Pletcher last year for mental behavioral health, a high risk population, HCCs worked on Physiological First Aid, KS needs to build on that and he will talk with Jamie later	2. Tom Pletcher will talk with Jamie about expanding work with the physiological first aid
KDHE Updates/HPP Site Visit Report-Carmen	• Budget ○ BP4 are expecting FOA in early February • Hospital surveys ○ Due Thursday, January 22, 2015 ○ Not all facilities responded ○ Unsure how the survey data is being handled ▪ Asked Mindee and Michael if this information will be shared, or if this made the hospital accountable in any way ▪ See "other business" • David Marshall is the new Operations Specialist ○ Jurisdictional Risk Assessment is his main focus until completion ○ He is retired Navy, came come KDOT, he does not have a lot of experience with preparedness but is looking forward to working with everyone to complete the JRA. •	***Outcomes-*** ***Action Items—***
National HCC Conference-KDHE/KHA/Coalition Members	• 32 people went to the Denver Conference in 2014 • 45% of the total budget was spent to send members to the conference • Discussion over the benefits/areas of improvement ○ Sue thought the sessions were very helpful, and it is very beneficial to send people to the conference to get the information back—note: so many people went, there	***Outcomes –*** Denver HCC Conference was not well received. The committee agrees spending 45% of the budget was not the best choice and understands sending many people too many conferences will be a better use of resources.

	doesn't need to have a debrief of the conference o Presenters were unorganized and unprepared to talk about the subject o Seemed like the presenters mostly discussed the topics with each other o Networking, interactions and workshops were good and thought provoking , however had to sign up for the workshops and the workshops were not consistent to how they were organized so not all were beneficial o There was no Primary Care representation/discussion, is not worth the time of PC to go back o As a presenter: the poster presentations were not organized and no discussion took place during that time. It was confusing trying to find the posters and the abstracts and posters were not organize in the same order so it was distracting thus caused people to not attend the poster presentations o Cindy Mullen liked the early morning sessions that were very small specific groups, these small groups were very helpful and beneficial since they provided an opportunity for feed back o This is the third conference and there is a lot of growing pains, most of the presentation did not stay on topic, seemed like a "bait and switch", the title seemed great but the discussion was not helpful or off point o Like having all the partners come together in one place and discussion that happens • Alternatives o Most of the feedback isn't good, and implies this is not a good use of money o Should the regions or a subcommittee need to determine which conferences would be a good use of resources o There needs to be a conference that is more in line with	***Action items*** – 1. Regions will research conferences their HCC members would like to attend and report back to the committee

	Kansas risks, like rural public health and health care o Each discipline has their own conference, should the HCC send individuals to the conferences, and have the individual report out ▪ Having some representation from each region would be beneficial ▪ Discuss what is happing in Public Health, Emergency Management and other specific disciplines o Nebraska has developed a new conference, their demographics is very similar to Kansas o We ask each region to research the different conferences and bring back to the group those findings ▪ Members can go to different conferences and report back to the committee o Would be nice if Kansas can hold their own conference ▪ SC ESF 8 Symposium is a great conference and a lot of information and networking is shared at that conference	
NEKS Capability and Resource Assessment for Coalitions- Jason Orr	• HANDOUT: PPT slides o Start on page 4, the one in our packets was for the county commissioners o Local and regional assessments were prompted by the discussion at the National Healthcare Preparedness Conference o Competency assessment started several months ago at Riley County Health Department o Recognized HD staff have their normal roles, like WIC, but when there is an emergency they have a completely different role o Riley County took a baseline assessment of workplace emergency competencies ▪ Used a 1-5 scale ▪ Focused on fire, safe haven	***Outcome—*** NE planning subcommittee is working on competency assessments, they plan to have more information in 6 months ***Action items*** – 1. Jason to send assessment to Laura to attach to the minutes 2. Sue to send Jason her Risk Assessment tool 3. Anyone who is interested in giving additional information that may benefit in the generation of survey questions, please forward to Jason Orr a. Riley County Health Department,

	▪ Will use this to develop training and exercises o The Survey is based from Columbia University School of Nursing Center for Health Policy ▪ Developed to assess the HD staff to acclimate to an emergency role ▪ A sample question: how accurately the staff member can recite the ICS structure ▪ Riley County will administer the survey next month and will follow up in about 6 months o Competency assessment ▪ 15 questions, with sub questions ▪ Capability assessment have a lot more questions ▪ PPT has some samples of the questions ▪ Question may be more specific for certain capabilities and training for staff, like NIMS and plans ▪ Leadership assessments may include questions concerning relationships with partners, and communicating with the public ▪ The assessment is a pretty quick place to state with the broader emergency planning within the HD • Planning subcommittee in NE HCC focus o Capability and resource assessment ▪ Adapting the CDC community assessment tool • Assesses the capabilities to find gaps • Uses an all hazards approach • Geared toward building plans and collaborations ▪ There is a hospital only assessment too ▪ Very good to use at the regional level o Evaluating the many assessment surveys to see which will be most valuable in their regions to determine competency	office: 785-776-4779 ext. 7633, email: jorr@rileycountyks.gov

	▪ Do not want people to complete the same set of questions over and over o Looking at a 2-part approach to gaining insight of the region ▪ 1. An assessment completed by the community planner to give a general view of all agency's in the region, and to gain broad knowledge of the community ▪ 2. An assessment completed by specific agencies, to get a deeper understanding ▪ Not all communities/agencies will have a two part survey • Discussed the survey's questions specifically (see PPT) o Each sector has a set of question for their area, and each agency has very specific questions o Not all questions in the community assessment tool will need to be asked ▪ Focus is for HHS/KDHE to be able to see the deployable assets and what stockpiled assets the region has o Behavioral health aspects are included o How a facility may handle surge, contaminated, ill patients ▪ Has been lacking in national surveys o There is also a resource assessment that goes further into the region's resources, and covers more than just hospital's and public health's resources ▪ Asks about the general resources, there will need to be additional work to discover the specific type of resources we want to know about • Using Survey Monkey o Allows the questions and answers to be exported into a spreadsheet	

	• Expanding the scope of the survey
	  o Need to include all the necessary questions, but cannot get too big because then people will not use it
	• Discussion
	  o Assess the regions' capabilities
	  ▪ Coalition development doesn't go all the way into capabilities
	  • May be able to monitor NE and tag along into what they are doing
	  o Sue is working on a Risk Assessment survey
	  ▪ Looking for gaps in the region
	  ▪ Sue will share with Jason
	  o This will be helpful at the state level, use the existing data in a new way
	  o Jason will send Laura the assessment to attach to the minutes	

Role of Centers for Medicare and Medicaid Services in Disaster Response-David Wright	• Conference call—David Wright
	  o Centers for Medicare and Medicaid Services Deputy Regional Administrator Dallas Regional Administrator
	  o Other information
	  ▪ David will be in Kansas City February 17-19, he will be willing to do a meet and greet
	• HANDOUT: PPT—Purpose of 1135 Waivers
	• Purpose of 1135 Waivers
	  o Meet the needs of your community to provide medical services in response and recover with an event
	  o Bottomed line: get regulations out of the way
	  ▪ do not have to wait to evacuate patients or do anything in response to an emergency event
	  o waivers are retroactive
	  o none of this should impact the response activities, care for the patients first, get waivers second
	• To issue a waiver there has to be a health emergency declared
		Outcome—
		1. Please contact David Wright with CMS-Dallas with any questions regarding the 1135
		  a. Desk: 214-767-6426, cell: 214-930-8476, email: david.wright@cms.hhs.gov
		Action—

	by o Presidential Declaration and Secretary of HHS o Doesn't matter what order, but both must be in place to issue a waiver o Usually if there is a presidential declaration, can get the secretary's declaration very quickly ▪ Will work with both parties to ensure this has happened if a waiver is necessary o State declaration of an emergency ▪ Does not have the authority to implement the waiver • Considerations for waiver authority o Scope of the severity and the impact of the health care infrastructure ▪ Example: Joplin tornados, huge impact on the community and to the health care infrastructure; the blizzard in Buffalo did not impact the health care infrastructure o The needs of the healthcare providers are not being met ▪ If they can be met by the current regulatory authority, then they do not need the waiver o Waivers will only be put into place if there is a need ▪ Time limited and temporary o Facilities does not need to wait for the waiver, they can do the patient care with the waiver because CMS can provide the waiver retroactively ▪ Hospitals should be aware of setting up alternate screening sites, or other things that will stay within the current regulatory authority, because they will not need the waiver and one will not be issued • Examples of 1135 Waiver Authorities o Please see PPT o They waiver things so facilities can get paid for services	

from Medicare and Medicaid
    - Example: physicians to travel to provide care for patients
    - EMTALA/HIPAA waivers are issued because there are situation where you cannot completely and adequately safeguard the patient information but still need to treat patients effectively
- What Waivers DON'T Do
    - They are not a grant or financial assistance program
        - No additional money
        - Cannot help with recovery
        - They will only allow for reimbursement for eligible services only
            - Example: will not pay for boarding and the waiver does to change the Medicare payment position
    - Doesn't expand the scope of eligibility
    - Does NOT affect the response decisions
        - Do NOT call CMS for any response suggestions
    - Waivers do not last forever
        - Appropriateness may fade as emergency evolves, for example, if you apply 3 days out compared to 30 days
        - Remember: waivers are temporary
    - Waivers do not override state statute, they only apply to federal requirements
- 1135 Waivers
    - EMTALA- most usable
    - CAH- can exceed their 25 bed statute and can stay longer than 96 hours
        - Act as a surge capacity
        - Based on need—all waivers are based on need, will not issue a waiver if there is no need

	o Skilled Nursing Facilities—less acute patients can be moved to the nursing home, or if there is a need skilled intervention without going to the hospitals o Other ▪ Waivers are retroactive • Waivers are turned around in <24 hours, usually <4 hours ▪ A lot of facilities have the infrastructure in place to exceed their capacity, so they can have a waiver to waive their limit temporarily • 1135 Waiver Review Process (to increase the amount of beds in the CAH) o Is it within the emergency area o Is there an actual need o What is the expected duration? ▪ CMS will not approve something that will last several years ▪ If a facility is only able to operate under waiver protection, CM S will not issue the waiver, because waivers are temporary only ▪ CMS will get the expectation from the provider how long the waivers expected to use o Can this be resolved within the current regulation ▪ If there isn't anything in the 1135 waiver that will help the facility then CMS will not issue the waiver o Should CMS consider an individual or blanket waiver? ▪ CMS can issue a blanket waiver to all the facilities across the impacted areas so each individual facility doesn't have to ask for it • Waiver Review Inputs o Facilities need to supply input to the CMS o CMS doesn't affect the state regulation, cannot override the state	

	• Expectation of Waived Providers
	  o Providers will need to supply sufficient information to justify actual need, they can communicate to CMS in any way, they need to know what is going on so they can address the requirements for approval
	  o Must keep good records, they will have a disaster asterisk
	  o Providers will need to resume compliance to normal rules ASAP
	  ▪ They want everyone back in place BEFORE the waiver runs out
	• David's contact information
	  o Can call CMS at any time. Don't hesitate to call David the less healthcare providers have to think about CMS during a disaster, the better; healthcare providers should only focus on the health and safety of the community
	• Questions:
	  o What happens if a hospital asked for the waiver and they are outside the region of the disaster? Wichita is a ____site and accepts patients and the facility is more than likely outside the declaration area?
	  ▪ The waiver would not over the facility; CMS will work on enlarging the scope of the area, if they are aware of it, if here is no other options, then the declaration area will need expanded. CMS is working on getting declaration areas changed into something more realistic
	  o What happens if the facility is outside the devastation area, or if there are a lot of hospitals are impacted outside the immediate areas? Will all the hospitals outside the area have to make a request for the waiver?
	  ▪ Something that widespread, CMS will work with the system, because they understand how to	

	modify the abilities for the recipient facilities to accept patients. CMS will give a blanket waiver in that case. When it is that widespread, the scope of the declaration to have the receiving facilities to have the waiver needed to be able to accommodate the patients they are receiving and issue a blanket waiver and for the CAH that is what we will do. Most of our events there are incremental impacts on the receiving facilities, when more people are impacted they will become involved with the response. Early on, CMS would make sure the scope is expanded enough so the individual hospitals would not have to individual waivers o On a waiver, CAH can increase bed capacity, but CAHs but they have to average 25 beds a year, does the waiver overrule that Medicare rule? ▪ If at the end of the year, it exceeded the yearly rule, then that would be allowable. o What about issue of a waiver authority for licensure or issue for liability and malpractice? ▪ Waiver doesn't do anything to address that, it only allows for reimbursement. The state licensure has to allow the doctors and nurses to practice in the state during the event. The waivers do not touch on liability and malpractice. *The board will probably not act as quickly as the waiver though…* That is probably true, that happened with Joplin the medical board allowed doctors to come in as soon as they realized they could get a waiver, however a waiver does not have any impact until the state boards do their thing o Are there waivers for life safety codes	

	▪ Not directly. A couple of things, example: nursing home can evacuate into high school gym, that is fine and it is safe for them, but after a while not very safe, we would hope there will be a more suitable environment for the needs of that population. We will look at that, if the facility is without power, you will have a fire watch and other things in place to make sure the residents are safe. Maintenance life safety codes will be waived, do not know if any real impactful life safety codes will be waived that actually will impact the safety of the residents. We will not waive the life safety things that will most likely have an adverse response for the patients, like who can distribute drugs. o So you have no waivers that will allow extra beds in an egress hallway? ▪ You can do that, you have to look at what you are dealing with. Example, you will have to put the residents wherever you can because they have nowhere else to go. But then you know you will have to move them and get them into a better place. We assume after a day or two you will move the folks into safer environments o What about other requirements for facilities? Like if the hospital can no longer meet the requirements? ▪ If it can't be a hospital at all, then what we can do is put them in suspense. If there is a lengthy renovation so they don't have to reapply for Medicare/Medicaid certification. If there is a couple of year then we will terminate the number and restart. They can maintain their	

	certification with temporary mobile units, vacant wings and by maintaining their staff. We work with inoperative facilities, once they come back then we expedite the process o What about provider definition, it depends on the set up; if a hospital wants to set up a sit outside the region where the provider base is? ▪ Yes, the waiver can be used. Once the waiver expires they can't use that [facility], they will have to move it. Remember you can have a provider base unit within 35 miles without having the waiver in place. A lot of that depends on what is being set up and where it is being set up. We can have a lot of discussion to make sure we decrease angst o Does the facility EOP need to address how they will do this during different events? ▪ No, we do have the proposed emergency regulation this year; it will have more robust responsibility on the Medicare facility to maintain service during an emergency. [The proposed regulation] will ask if the facility is doing the things we require like maintenance and the drills, so you will have to have an emergency operation plan that is effective; when the proposed emergency regulation comes out in final o Please call David or contact him at any time. Kansas emergencies aren't as planned as other states (they know three is going to be a hurricane days before they hit). David will help you plan and do exercises. He wants to ensure we have all the information we need—thanks!	

Statewide Healthcare Coalition Steering Committee Meeting – 01/26/2015

Nomination of Vice Chair/Next Meeting	• Virginia is chair
	• Richard nominated Michael Burkhart for vice chair and Karen seconded the nominations
	  o Michael Burkhart is now the vice chair
	• Carmen, on behalf of KDHE, would like to thank Charlie for his hard work and dedication he has put into the HCC Steering Committee
	  o The committee agreed with a standing ovation
		Outcome—
		1. Mike Burkhart is the new vice chair
		Action—

	•	
Regional Updates	o	

Other business	• Steering Committee (see agenda item: Leading Age)
	  o Should the committee size be reduced?
	  ▪ Is it necessary for all the hospital coordinators be on this steering committee? The hospital coordinators are established and have a very good communication relationship
	  • Hospital: we use this meeting to meet right after, and the people at this committee table right now are very needed
	  o Restructuring the subcommittee
	  ▪ Developing subcommittees
	  • Allow the subcommittee to work on their work and present to the entire group
	  • Subcommittees need to meet face to face because it is always a back burner if
		Outcomes-
		Discussion on the size and format of the steering committee. Discussion on the assessment survey distributed to hospitals.
		Action items –
		1. Members need familiarize themselves with the mission/charter of the committee and reflect on the committee members and actions to ensure they align with the objective of making Kansas better
		2. Members need to evaluate how/when the committee meets and be able to discuss viable options
		3. Virginia to include committee format into the next meeting agenda
		4. Carmen to disclose how the hospital

	only communication is through email and phone o Meeting dates and times ▪ Entire committee meets twice e a year, subcommittees meet quarterly ▪ Subcommittees meet at 8:00, committee meets at ten on same days o Members ▪ All members currently at the table are necessary ▪ NEED to get long term care represented o Reevaluate the Mission/Charter ▪ Need to focus on the area that do need to be represented ▪ We need to ensure value is maintained within the committee ▪ All subcommittees need to be developed around the mission/charter to ensure they have value to the committee ▪ What should this group do? • Explore the health and medical objectives in each region • Need to address the needs of all the regional councils, with the objective of making Kansa better • Ebola assessment/Treatment Hospitals in Kansas (see agenda item: KDHE Update) o Currently there are not hospitals in KS that have identified as an assessment or treatment hospital ▪ There are two random dots on the CDC map that refers to two hospitals that can potentially treat an Ebola patient o KDHE just finished a survey that identified at least 2 potential assessment hospitals in Kansas ▪ The survey does not have any question as to	surveys will be used a. *Note: After the meeting Carmen received an email regarding this topic. If a hospital falls into the category of a potential assessment or treatment facility, the hospital will be contacted directly and individually to discuss the possibility of gaining that recognition*

	how the hospital feels about becoming an assessment or treatment hospital ▪ KDHE cannot just assign the hospitals! How will that be handled politically? • Carmen doesn't know, she will relay that information as soon as she gets it (see outcomes) o CDC has asked KDHE to identify assessment and treatment hospitals ▪ CDC will would like to see an assessment hospital within 1 hour of 85% of the travelers ▪ KDHE is asking if we can identify hospitals by regions not city or county because that will narrow the scope making it too easy to identify the hospital—have no feedback yet o Funding for Ebola preparedness ▪ It is in part based on risk, it is unknown if assessment hospitals will get more money ▪ KDHE would like feedback from this committee about funding, if we can ▪ Hospitals want to get reimbursed for the PPE, either at the hospital level or the regional level ▪ It may be advantageous to mention if assessment hospitals will receive more money o KDHE still urges hospitals to be prepared to take care of a patient until rule out for at least 72 hours ▪ CAH guidance suggests 12-24 hours and have MOUs in place for a transfer o Request: if there is a request made to make a hospital an assessment hospital, please discuss with the hospital coordinators so the CEO isn't blindsided, it would be very helpful for the coordinators as well as the CEOs to be more comfortable with the discussion	

Next Meeting	• April 20, 10-2, Salina, KS at the Rolling Hills Conference Center	